MINUTES
(Approved by the Committee)

MEDICAL EDUCATION INTERIM COMMITTEE

August 12, 2008

Len B. Jordan Building
Clear Waters Room (3rd Floor)
650 West State Street, Boise, Idaho

Members in attendance were: Senator Robert Geddes (Co-chair), Senator Bart Davis, Senator Dean Cameron, Senator Diane Bilyeu, Representative Maxine Bell (Co-chair), Representative Lawerence Denney, Representative Fred Wood, and Representative John Rusche. Ex officio members in attendance were: Dr. Steven Daley-Laursen, Interim President, University of Idaho; Dr. Art Vailas, President, Idaho State University; Mr. Bruce Newcomb, Director of Government Affairs, Boise State University, who was representing Dr. Mark Rudin, Vice President for Research, Boise State University; Ms. Susie Pouliot, CEO, Idaho Medical Association; Mr. Steve Millard, CEO, Idaho Hospital Association; Mr. Milford Terrell, President, State Board of Education; and Mrs. Sue Thilo, Secretary, State Board of Education. Legislative Services Office staff in attendance were Matt Freeman, Maureen Ingram and Charmi Arregui.

Other attendees present were: Dr. J. Kent Caruthers, Senior Partner, MGT of America, Inc.; Representative Anne Pasley-Stuart; Representative Susan Chew; Kathie Garrett, Family Medicine Residency Idaho; Ken Edmunds, State Board of Education; Mike Rush and Mark Browning, Office of the State Board of Education; Andrew Turner, University of Idaho-WWAMI; Joyce McRoberts and Clete Edmunson, Governor Otter's Office; Corey Surber, Saint Alphonsus; Denise Chuckovich, Idaho Primary Care Association; Jayson Ronk, Idaho Association of Commerce and Industry; Micah Kormylo, representing Jeremy Pisca, Evans Keane; Ken McClure, Idaho Medical Association; Kent Kunz and Kent Tingey, Idaho State University; Wayne Hammon and Richard Budzich, Division of Financial Management.

Senator Robert Geddes called the meeting to order at 9:33 a.m. He stated that several years ago the Legislature appropriated $300,000 to engage in a medical education evaluation or study; that money was managed by the State Board of Education (SBOE) and they hired a consultant to implement the study. He pointed out that former **Senator Joyce McRoberts** is managing the Governor's Select Committee on Health Care. He said the members of this committee were called together to evaluate the existing effort with regard to medical education, hoping to gain a common base of understanding to develop a common effort to determine what is best for Idaho's future with regard to medical education before the 2009 Legislative Session commences.

Senator Geddes said that all participants in this meeting will help to evaluate what Idaho has currently, what the future looks like with regard to medical education and the need for additional

physicians in our rapidly growing state, and what the members, as decision makers can determine what is the right, best approach for Idaho.

Mr. Milford Terrell reported that there are currently four studies going on: this legislative interim committee, one from the State Board of Education, one from the Governor's Office, and an organization in northern Idaho has also begun a study. He asked what the intentions were, how these various studies could come together, and how a final result would be presented to the Legislature, asking if there will be four separate reports. **Senator Geddes** replied that he cannot dictate how the State Board or the Governor's Select Committee on Health Care should proceed, adding that he wasn't familiar with the other group. He said his vision was to study this subject, money having been appropriated to allow that process to engage and take place. He said that the investment of the citizens' money to complete a medical education study was significant and he did not want that final report to be shelved, thus the reason for **Dr. Kent Caruthers** being invited to present the findings from the Medical Education Study Final Report. **Senator Geddes** stated that the committee's premise is to first evaluate what has already been done, then come to a consensus as to future needs for Idaho to provide medical services to citizens, recruiting necessary physicians, or perhaps training physicians within Idaho. **Mr. Terrell** asked where **Senator Geddes** would like this committee to be, at day's end, and what they would like to accomplish to facilitate the next meeting. **Senator Geddes** stated that his anticipation was to build a common understanding, a good foundation to build upon in the future, and he encouraged discussion about what needs to be the next step.

Dr. Kent Caruthers of MGT of America was the Project Director for the Medical Education Study in 2007. He said MGT's interest in medical education began a decade ago when Florida was experiencing issues relating to medical manpower. The Florida Legislature hired MGT to study medical adequacy within the state; they did that and then were engaged with Florida State University to develop a plan for the first new medical school in the country in over two decades.

Dr. Caruthers said that this Medical Education Study Final Report had a legislative deadline of November 1, 2007, and the summary of this report was originally presented to the Idaho State Board of Education on December 6, 2007. He emphasized that MGT has not been engaged in this study for almost a year, adding that since medical education is a very dynamic issue, new proposals and data may now be available that may not be reflected in his presentation today. **Dr. Caruthers** stated that his presentation had three major components: (1) project background, general information about medical education including the state's current investment in medical education; (2) analysis of the state's current and future needs related to medical education and the medical workforce; and (3) assessment of advantages and disadvantages of different alternatives presented in the report to expand medical education in Idaho.

Dr. Caruthers' presentation is attached to these minutes (Attachment 1).

Dr. Caruthers said that 16 of the 22 newest schools were based on the distributive model which has become much more prominent, stating that students might take their first two years at a university and then go out to community hospitals. Typical medical schools might have ten applicants for every seat because of multiple applications, many more applying than are ever

admitted.

Dr. Caruthers said there are different types of residency programs, hospitals being the primary sponsors, as well as medical schools, Veterans Administrations and various community-based organizations. There were about 103,367 medical residents in 2005; 28,149 were filled by international medical graduates with 38,207 first-year residency seats, part of the issue here being lack of access to residency programs as well as to medical school seats.

Senator Geddes asked if this meant that international students were receiving their medical training in the U.S. or in foreign countries and then doing their residencies in the U.S. **Dr. Caruthers** answered that an international medical graduate meant that they had graduated from a program outside the U.S., even though perhaps a U.S. citizen, who had not been admitted in a U.S. medical school. **President Vailas** said that many residency programs require a medical school sponsor, only a few can be totally sponsored by a hospital only, asking **Dr. Caruthers** if that was correct. **Dr. Caruthers** said he was not an expert on getting a resident program accredited, adding that the ones he knew about were affiliations between hospitals and a partner medical school. **President Vailas** said that the point he was trying to make was that if one looks at graduate medical education requirements, most specialties require accreditation of a medical school, even though they may have affiliate hospitals, with the exception of family medicine.

Dr. Caruthers said that the state of Idaho has three state universities invested in pre-med programs with faculty active in biomedical research.

Senator Diane Bilyeu asked about resources for medical education in Idaho and if an inventory had been done about what different institutions have available from the standpoint of classes. **Dr. Caruthers** answered that there is information in the binders provided to the committee members (under section 2, the last four pages containing that information, a copy of which is attached) (Attachment 2). **Dr. Caruthers** added that there is an exhibit in the supplement to that report that talks about specialized equipment used in medical education. He said that he did not have any specific plan from any university to expand, so they were generically looking at types of things that could be made available to a potential medical school, adding that presumably three Idaho universities have facilities because they have other programs using these facilities, making no judgment on excess capacity. **President Vailas** said that a correction should be noted that the Pocatello residency program is accredited through Idaho State University in addition to affiliations with the University of Washington and the University of Utah.

Mr. Milford Terrell said that the State Board of Education (SBOE) had not reviewed with the university presidents this information, and he invited the university presidents in attendance at this meeting to review these last 4 pages under section 2 in their binders and to contact the SBOE if there are any corrections.

Dr. Caruthers then talked about the Association of American Medical Colleges' (AAMC) goal to expand the number of medical school seats by 30% over the next decade.

Representative Bell asked if the AAMC has a work plan to reach that goal for expansion of

medical school seats, other than leaving it up to others. **Dr. Caruthers** said he didn't believe that, as an entity, the AAMC has a work plan, adding that the AAMC does have conferences, physician papers, research of schools and expansion plans, but said that they are not in the business of funding additional medical school seats.

Dr. Caruthers then focused on the need for physicians in Idaho. His team looked at the number of physicians actively treating patients in Idaho as being 162 per 100,000 population, adding that the national average is 239 per 100,000, Idaho ranking next to last of all states.

Senator Geddes asked if that meant that the citizens of Idaho are twice as healthy as in neighboring states or that Idaho's citizens are going elsewhere to receive medical care, or perhaps not receiving medical care. **Dr. Caruthers** said he suspected that it might be all of the above.

Representative Rusche asked if MGT had looked at, or is there a way to look at, other practitioners such as nurse practitioners, physician assistants who may be extending the outreach of practicing physicians in Idaho. **Dr. Caruthers** said that he believes there is a way to gather that information but that MGT was not charged to do that. He admitted that there is a concept of physician extenders including other professionally trained health care workers that do some things physicians do, adding that those professions such as physician assistants and nurse practitioners are growing much more rapidly than the M.D. professions, in terms of number of graduates.

Senator Geddes addressed the two physicians on this committee, **Representative Rusche** and **Representative Wood**, about what they found to be intriguing statistics, wondering if Idaho's physicians put more time and effort into their practices to keep up with the need.

Representative Wood said that Idaho, in effect, has three distinct populations with respect to how citizens seek medical care: Northern Idaho seeks tertiary care from the Spokane area; Southeastern Idaho seeks tertiary care in Salt Lake City; the Treasure Valley area seeks tertiary care from Boise and when you look at physician density, wherever you have tertiary care you're going to have significantly more physician density than you are in areas where you don't have tertiary care. He said that Idaho will be significantly lower principally because Idaho is geographically a state that is spread out and has three distinct centers of population, two of which require a shorter distance to travel to other states to seek tertiary care. He therefor believes that this should be definitely taken into consideration going forward, believing that even though Idaho ranks low, that it is erroneous information to base anything on.

Dr. Rusche spoke from his experience as a physician as well as a health plan executive trying to arrange for caregivers for Regence Blue Shield. He said that there is a migration in Idaho for tertiary care, although many communities in the state have developed fairly good programs, such as in Coeur d'Alene and Idaho Falls. He believes the real issue Idaho has had, and he believes will continue over and over, is the fact that Idaho is facing a big problem with primary care physicians. They are aging, being trained to practice as part of a team and are being asked to practice in rural areas where there may not be a team. He believes that Idaho is delivering fewer

services; looking at Medicare data on the per-patient cost in Idaho compared with a more urban area, Idaho gives about two-thirds the amount of services to patients of the same age, with same illnesses. He admitted that some citizens do go out-of-state, but access is a real challenge to some of the population, and if a citizen could get access, sometimes there isn't a physician available.

Senator Geddes commented that some of our state actually receives out-of-state clientele for medical services, guessing that some Oregon or Wyoming residents come to Idaho for medical care, adding that Idaho receives import as well as export with regard to medical care. His question was if citizens are leaving the state for medical treatment, do these other states have the capacity to absorb Idaho's citizens and are they overstaffed to take care of Idaho's excess.

Dr. Caruthers said that he recalled that Washington does more closely meet the national average, and he wasn't sure about Utah.

Senator Cameron asked if the migration out of Idaho to seek medical care elsewhere is caused because of lack of physicians or is the lack of physicians being caused by the migration out of Idaho. He said if the answer is that the out-migration is caused due to lack of physicians and care, then would it be reasonable to expect that if you improved the opportunities for care, some citizens would remain in Idaho for care. **Representative Wood** said that he was trying to point out that where you have large tertiary care centers, the physician density is going to be significantly higher than it is in areas where you don't. He said that is strictly because of the way Idaho has developed, and as population centers develop closer to Idaho's borders, then that has some relevance, but it has to be put into its place. He said that Idaho is simply never going to have physician density that Utah or Washington has; if someone is going to use that statistic to base the need for a medical school or residency programs or to develop an infrastructure, then one needs to ask if people from Idaho Falls and Coeur d'Alene are going to come to Boise for their medical care, and he said he did not think they would. He was simply pointing out that everyone should be careful what they use that statistic for.

Representative Rusche said that based on his experience at Regence Blue Shield, they paid approximately 20% of their claim dollars to out-of-state facilities and physicians. He said he is more willing to accept it as a deficient supply.

President Vailas commented that, unequivocally, people are getting older and are living longer in this country, whether in rural or urban areas, and the probability of requiring services beyond primary care becomes higher and higher because more complications occur later in life, so there are access shortages in Idaho and in other bigger cities all over the country for both primary care and specialty care. He said that people will be living longer and Idaho hopes to become greater in economic development in the next five years and there will have to be some strategy in which the state has to provide services to contain health care costs. As you improve and increase the opportunities for citizens in any state, that is a significant savings to the state in trying to hopefully have that same access and services in places that are intended to have preference for their own citizens.

Mr. Terrell asked if someone could put these issues into a white paper, including the thought process behind why they feel the way they feel in each area.

Senator Geddes said they would try to do this and develop some logic, and that he had tried very hard to understand the interpretation of both **Representative Wood** and **Representative Rusche** on how they would interpret the statistics of Idaho ranking very low with regard to population and physicians per capita, learning a great deal from their expertise. His concern was that if Idaho was low-based on the rationalization that has been heard in this meeting, that is one thing, but if you look at all the indicators, Idaho is virtually last in every one. It seemed to him that Idaho's being 50 out of 51, 8 out of 8, etc. indicates there is something being taken for granted that is happening within our state and that this should lead this committee to evaluate the data very carefully, according to what **Representative Wood** and **Representative Rusche** had said. Are we providing for the needs of our citizens now and what do we expect to happen in the future relative to what is being seen now? His concern, as he read this MGT report, was that this is not necessarily an Idaho problem, the general consensus being that not enough physicians are being trained to replace those retiring in the near future or the demand is simply not being kept up with. Some statistics can be rationalized in various ways, but he thought that something needs to be changed within Idaho to either attract physicians from other states or to allow more of our own residents to have the opportunity to become physicians so that in the future more will choose to practice within Idaho. He sees an overwhelming need for more professionally trained medical professionals, the statistics now reflecting the need for better solutions in the future to accommodate the needs of our state.

Senator Cameron commented that he wasn't surprised that Idaho was significantly low with regard to health care issues; he was inquiring about what **Representative Wood** said, asking whether there was any study done to differentiate between the traditional family physician versus a specialist, in weighing averages. He believed that previous studies showed him that one of the reasons Idaho has higher health care costs is because there is a lack of traditional family physicians, not specialists necessarily, in Idaho. He asked if anything had been done to narrow that scope down. **Dr. Caruthers** said that MGT had not run their numbers based on primary care and speciality care, admitting that it could be done, but was not done as part of their study. He hears across the country that more medical students tend to be doing residencies in specialty areas, and residency slots are in primary care. He said that particularly for rural states, the best a rural area can do is hope to get a family physician, and rarely one with a specialty.

Representative Wood explained that a much more accurate figure would be how many primary care physicians by specialty we have per 100,000 population in Idaho versus Washington, Utah and other states. He said that would be a much more reliable number and a more indicative number of what is going on.

Senator Geddes commented that he thought that to be a very important point, since Idaho's whole medical treatment capacity has been based not necessarily on the boundaries of the state of Idaho, but where citizens can go to receive the help to address Idaho's needs. He said that in the past Idaho has perhaps been more dependent on other states or regions with better medical expertise, than we may want to be in the future. Rural communities need physicians in rural

areas to be able to refer to specialty areas in other parts of the state, and even that is becoming a challenge.

Mr. Bruce Newcomb commented that it should be determined what the basic premises are, the one being that there may be a shortage of physicians for various reasons in Idaho, and the aging adult population is looming as a challenge in the near future. He said that with regard to **Representative Wood's** assessment as to demographics, it seemed to him that ultimately the question comes down to how this problem is going to be addressed. Every rural state in the nation, he believes, has had a problem for years with physicians wanting to practice there primarily because they usually choose a more metropolitan area to practice. He said that nurse practitioners have been used for outreach, wondering about solutions for physician shortages, saying that he wasn't sure if the MGT study answers all of these questions.

Senator Geddes asked how other states were addressing this same concern, guessing that other surrounding states are having these same discussions. **Dr. Caruthers** answered that the University of Utah has an expansion plan underway, recognizing their problem and having a proposal before the Legislature. Oregon had a big expansion plan underway, with an affiliate campus. The University of Washington and each of the five WWAMI states has been expanding in some way, Washington having added a new training site in Spokane, as well as the ones in Pullman and Seattle. Alaska has about twice as many slots, he recalled. California is planning on two new medical schools, Arizona, Texas and Michigan are planning for one each, Michigan being a state that is not growing rapidly but trying to build its economy; Florida is planning three new medical schools.

Mr. Matt Freeman, Principal Budget and Policy Analyst, Legislative Services Office, said that he would be addressing expansion activities across the country in his presentation later in this meeting.

Dr. Caruthers pointed out that Idaho's population is expected to increase by 35% between 2000 and 2020, among the fastest growing states, and that population growth will strain access to physicians. Idaho also has the sixth oldest group of physicians in the country, 40% of whom will retire in the next 10-20 years. He said that Ada County is close to the national average, looking at physicians per capita, so the best county is only average for the nation. Idaho would have to increase its number of doctors by 35% above retirements just to keep the numbers where they are today. He said that Idaho's population age 65 and over is projected to increase by 85%, the age group putting the most pressure on the health care system. The concern that MGT has tried to communicate is that the competition with other states for physicians, since Idaho recruits heavily from out-of-state, has become more intense as other states develop shortages as well. **Dr. Caruthers** said that MGT looked at the need for physicians as well as the need for educational opportunity for students. Idaho trails the nation and similar states in medical school seats per capita. He said that Idaho students have only one-third the chance of getting into medical school as students nationally.

Senator Geddes asked whether there is a bias against Idaho students and a bias for a particular student, if they are from a state having a medical school. **Dr. Caruthers** answered that it is not

an overt bias against Idaho students, he said it is a bias against Idaho and the other 48 states as well.

Representative Rusche said that based on his personal experience from long ago, in Michigan or Wisconsin, there was a certain percentage of the class targeted to be in-state residents; then there was the difference of in-state versus out-of-state tuition.

Representative Wood agreed with that, adding that Louisiana in 1968 restricted 236 slots at LSU School of Medicine to Louisiana residents only; the Legislature and most publicly funded institutions at that time had a restriction based on that. He said that is why anyone from another state who wanted to go applied to private medical schools. He asked **Dr. Caruthers** if information was available on how Idaho students fare applying to medical schools that don't have that restriction for public funds per 100,000 population, how many Idaho students are actually going to medical school every year, and the national average.

Dr. Caruthers responded that there were 63 first-year medical students who listed their home state as Idaho, presumably 28 of those 63 were with contracts; he said that he didn't know about those remaining 35 students. He said that Idaho medical students are much stronger than the national average.

Senator Geddes invited other attendees to comment on this.

President Vailas answered that Idaho State University gets many pre-med students. He said they do work with many other state schools, both private and public, and more relationships are being built, but actually everyone hopes that Idaho will have a medical school some day.

President Daley-Laursen said that students are well prepared and are looking for medical schools, adding that the trend in universities nationwide is to loosen control of in-state versus out-of-state students. He thinks that the trend in universities, in general, is that no single university can do everything it wants to do, so universities are looking closely at partnering across states and focusing on each other's strengths through sharing regional expertise.

Mr. Newcomb said that finding a solution in Idaho might include increasing seats in WWAMI and at the University of Utah, believing that Idaho needs to transition in as benchmarks are reached for critical mass. He said that when a population is sufficient to support the diseased population to support a medical school here in Idaho, he envisioned a partnership possibly between St. Alphonsus, St. Lukes and perhaps all three universities. For now, he said that there are offers on the table; the WWAMI program costs about $45,000 annually for students, and at the University of Utah the cost is about $35,000 annually. Those needs could be addressed by increasing opportunities, adding that there are other avenues.

Senator Geddes said that at some point this committee will have to evaluate what makes the most sense in how to get the best return on their investment. **Representative Rusche** said that he thought that the fact that Idaho is 48 out of 51 states (includes D. C.) points to a very basic policy question, that being: what chance does Idaho want to give Idaho students to attend

medical school, and should they have the same chance at an in-state medical school, in whatever format the state eventually decides to take on that. Should Idaho students have an equal chance with surrounding states or the national average. He believes that this committee should first address what basic policy questions they need to answer going forward.

President Vailas asked if the scope of the discussion was based totally on the issue of access or other dimensions, adding that medical schools do much more for states than provide access to students.

Senator Geddes shared his vision for this committee's efforts as that of looking at all aspects of this medical education issue and how best for Idaho to sustain a medical-professional community that will sufficiently address Idaho's medical needs appropriate now. Idaho needs to be able to provide now and in the future a good corps of medical professionals who can sustain and provide services necessary and appropriate to meet the needs of our citizens. He believes that to be the obligation of the Legislature, as university presidents, and there is also an obligation to Idaho students, especially in providing programs to prepare students for medical school, believing there are not enough alternatives or options for those students to be successful.

Representative Rusche thought it would be useful to truly assess what the need is on an ongoing basis. He said the committee was looking at national statistics that may be incomplete, certainly not portraying Idaho positively, and one of the outcomes this committee might want to consider is measuring and monitoring information on an ongoing basis.

Mr. Millard said that it is very difficult to recruit physicians to rural areas, saying that 26 hospitals are critical access (those having 25 beds or less). He said that rural areas have great difficulty getting physicians, often wanting a doctor such as a general surgeon, so they can generate more revenue to stay afloat. He asked about the number of physicians per 100,000 population, what the optimum number ought to be, and if the national average was optimum or not.

Dr. Caruthers answered "no." He said that if it were possible to set a service level standard, one might then work backwards from that to determine how many doctors are needed so that citizens don't have to travel more than a determined number of miles for a required procedure and wait long for an appointment.

Ms. Sue Thilo said that as the committee addresses better medical education access in Idaho, with high sensitivity to the physician shortage, she expressed concern about family practice doctor shortages, stating that many doctors don't choose to select family practice because it is difficult to make a living. She said that doctors are more attracted to specialty fields in large metropolitan areas, pointing out that Idaho also needs to look at what will attract physicians, especially family practice physicians, to Idaho.

Representative Rusche said that one of the "elephants in the room" is the pay discrepancy between specialty physicians and primary care physicians, and while that isn't the charge of this committee, he said he believes that it bears directly on the ability to meet the physician needs in

Idaho.

President Vailas reiterated that the issue is, what kind of organization must Idaho have to steward the changes that are going on in our country and in the world, so that Idaho is not left behind. Is it going to be the hospital by itself, the institutions by themselves, is it going to be a medical school? What is the organization that will work with both the political arm of the Idaho State Legislature and the educational system to make sure that whatever strategies are being changed in this country, that this state basically is not going to be left behind? The question, he said, becomes not just an issue of primary care or specialists, but rather a conglomerate of things.

President Daley-Laursen agreed with **President Vailas** in that he didn't think fixation on a certain problem such as ratios of physicians to patients will help this committee come to a systemic solution. He said one thing not mentioned is the dynamics in health insurance which have a huge impact, adding that his university has implemented a cafeteria system. This causes the public to begin managing their medical affairs along with their other financial affairs. Enrollees have to plan ahead, bank for their medical care, and make intelligent decisions every single day about what part of the medical community they are going to use, if any. His point was that we should be preparing a vision for what Idaho's medical health system should look like; government should lead, and higher educational institutions ought to help the state get there. He believes a vision should be created, based on all the data that can possibly be amassed, and not be fixated on any particular problem as a statistic data point, which may reflect the past rather than the future.

Dr. Caruthers addressed how to get more medical students into family practice, and one member of their team on this report felt strongly that the admission process to medical school is a key point in building Idaho's medical profile. If Idaho recruits students from small towns to medical school and gives them preference, those students would be much more likely to return to small towns to practice. He said there is also some predictability to identify students who want to pursue specialty practices. **Dr. Caruthers** said that Idaho trails the nation and similar states in residency program seats per capita. He believes that one particular problem Idaho has is that there are fewer residency slots then medical school slots, and since students tend to practice where they do their residency training, Idaho students are being forced to leave the state.

Mr. Newcomb asked what financially could be put toward that to change that factor. **Dr. Caruthers** said that funding graduate medical education is extremely complex, adding that generally the typical delivery model is a hospital-based residency program where residents are part-time employees (65 hours weekly) and being paid $40,000 to $50,000 annually. The hospitals are able to bill to some extent the services of those residents, and Medicare and Medicaid pays for a lot of residency programs; they also pay the direct costs (salaries) as well as indirect costs (program administration). He said that about a decade ago the federal government put a moratorium on authorizing new residency programs for new slots at hospitals that already had residency programs, so there has been a freeze. There are loopholes for hospitals that never had a residency program that might get federal dollars. He said that Idaho is funding some residency slots so the state could put forward more money than what they are currently, if necessary to build this up. He said that sometimes hospitals are more willing to step up to the

plate and invest money which they view as a recruiting tool. There are many payment schemes, he said, but the state could have a role, some states using their tobacco settlement to support graduate medical education and the health care needs of their state. Not only does Idaho have a relatively few number of slots for residency programs, but they are all in family medicine, so there are no stand-alone programs for residents in other areas or specialties. **Dr. Caruthers** said that a third component of need, besides physicians and student opportunity, is the role that the health care sector plays in economic development of the state. He said that some people argue that over time an investment in medical education is an investment that pays off in terms of state economy.

President Daley-Laursen said that the economic development piece obviously was very important in Idaho, expressing curiosity whether **Dr. Caruthers** had statistics on the current medical education research programs' return on the state's investment as compared to larger medical school infrastructure return on state investment. He quoted a $4.50 return to the state of Idaho on the state's investment in the current medical research and education program and about $2.35 return on average to medical school systems in other states. **Dr. Caruthers** said that during the course of his study, he was not made aware that there were state-level metrics on that or that multiplier. He said the national number mentioned is a number that is fairly common, and that the AAMC sponsors a study every few years. **President Daley-Laursen** said that what he was driving at was both that statistic, which he is very interested in the committee continuing to look at, and also exploring the vision for the future. He was also interested in having some expansion of the discussion about what kinds of investments will give Idaho the highest return.

Representative Rusche asked about Idaho's ranking 35th among states in share of state GDP, but 50th per physician supply, asking **Dr. Caruthers** to explain that. **Dr. Caruthers** answered that the amount is what is spent at pharmacies, nursing care and various expenditures, not simply physician services. **Representative Rusche** said that even though Idaho has a lower number of physicians and presumably services, Idaho has a higher cost in proportion, asking if that was what **Dr. Caruthers** was saying. **Dr. Caruthers** replied that he wasn't sure about higher cost; this ranking is noticeably better than Idaho's physician access ranking, and he wasn't sure what was contributing to that.

Representative Wood said he thinks it is worse, believing that Idaho is less efficient, but was not sure what was being measured here. He said this points to another "elephant in the room" which is the cost of health care, but he thinks this is a negative, not a positive.

President Vailas commented that the issue is: is the cost of health care higher when you have a higher percentage of health care availability out-of-service versus in-service? In Idaho, in its configuration to provide health care access and opportunity, is the cost higher if you have a large percentage of out-of-service or out-of-state providers rather than providers within the state?

Dr. Caruthers said that Idaho is near the bottom on key measures of physician access and student opportunity, adding that Idaho's rapid population growth will likely cause access and opportunity to further erode, the impact being that Idaho's citizens will face increasing difficulties in gaining timely access to medical care. He said they were asked to include in the

MGT report alternatives for providing medical education, but they thought that before that, the state needed potential state goals. MGT made some modest assumptions about potential state medical workforce goals indicating a need for major expansion of medical education. **Dr. Caruthers** shared some goals for Idaho through 2020 from their MGT report. He said they looked at four alternatives for providing medical education, and they came up with seven criteria for assessing the alternatives. **Dr. Caruthers** said that while MGT had come up with other preliminary alternatives for providing medical education in Idaho, such as a free-standing health science university similar to Oregon's, or creating an osteopathic school, they believed the four alternatives might be the most promising.

Senator Davis, in reference to MGT's potential state goal of training 80 new physicians through state-funded M.D. programs, asked how much the market today is solving our problem for us? How many new physicians come annually to Idaho and are licensed to practice medicine that are either D.O. or M.D.? **Dr. Caruthers** answered that he has seen that data on new licensures annually, expressing concern that as the national market tightens up, Idaho would have trouble maintaining ability to recruit from other states as well as respond to population growth. **Senator Davis** asked for that number as it exists today and perhaps historically. **Ms. Susie Pouliot** responded that she could make a query through the Idaho Board of Medicine, having the best numbers available. **Representative Rusche** asked also to differentiate active-practice physicians from licensed physicians since many physicians, prior to retirement, license in potential retirement sites.

Dr. Caruthers reiterated that MGT had focused on the need for providing medical education in Idaho, all agreeing there is a need, adding that there was no consensus on the solution to this problem.

Dr. Caruthers addressed assessment of a new, university-operated distributive medical school.

Representative Wood said that his understanding was that Idaho has significant, if not complete control, of the admissions policy, although set to a certain standard, for students who actually participate in the WWAMI program, and they do at this point in time attempt to select for primary care, etc., asking if this was correct. **Dr. Andrew Turner** responded that applicants to the WWAMI program in Idaho must meet the University of Washington admission standards. The Idaho WWAMI interview team, which consists of University of Idaho faculty and four Idaho physicians (appointed by the State Board of Education) selects, interviews, recommends and ranks students. **President Vailas** asked who then makes the final decision for selection. **Dr. Turner** said that the UW Executive Committee of Admissions makes the final decision, the membership of which is a proportional representation of all the WWAMI states. **Representative Wood** said that his understanding is that they can either accept or not accept the ranking, so he asked, do they ever not accept the committee's ranking, providing students meet the qualifications. **Dr. Turner** answered that, in the past, there have been times when the Executive Committee has rearranged some of the rankings, but stated that the new Dean of Admissions has said that Idaho's rankings stand.

Ms. Pouliot stated that several years ago the Wyoming Legislature approved increased WWAMI

seats, and with the extended number of seats, the pool of applicants had remained the same from one year to the next and, that particular year, the pool did not have the higher qualifications that students in the past had. With those dynamics, she said WWAMI was not able to fill all of their allotted seats for that year, emphasizing it was not a situation of Wyoming saying that they wanted certain students in, with Washington declining them acceptance; there was a minimum threshold qualification, and the pool of applicants was not up to those qualifications at that time.

Dr. Caruthers discussed the second alternative regarding expansion of contracted programs.

President Vailas said that these two alternatives are not based on what resources already exist in Idaho, but rather based on national trends no matter how you set up these programs. **Senator Geddes** reiterated that **Dr. Caruthers** had laid out various options to be considered, but not necessarily in priority of cost effectiveness or correlation as to what resources or assets are already available.

Dr. Caruthers referred to an earlier chart, saying that the WWAMI performance of returning doctors to the state is similar to what other states have in their own in-state medical schools, being fairly strong. However, when a medical student is sent out-of-state, 28 slots increasing to 80, WWAMI can take perhaps only 20 more of those, meaning that these 30 or so students sent out-of-state for four years may not come back.

Senator Geddes pointed out that Idaho is spending about $40,000 annually on WWAMI students with no real guarantee that any of them will come back to Idaho to practice; he asked if any of the other WWAMI states have any restriction on the fact that if they receive a benefit from the state, they have to pay some of that back or come back to practice. **Ms. Pouliot** said that Wyoming joined WWAMI in 1998, and when the Legislature made that commitment, they decided to impose a service/pay-back requirement. Students who have their education subsidized by Wyoming through the WWAMI program are required to practice in Wyoming for three years. If students attend one of the family practice residency programs in Cheyenne or Casper, each of those three years of their residency counts toward one year of their pay-back. If they do not return to the state, they owe the amount of tuition plus interest to the state of Wyoming. **Senator Geddes** said that it was his understanding that Idaho has no such provision; Idaho allows medical students to be subsidized and hopes they might come back to Idaho. **Ms. Pouliot** said that is correct. **Senator Geddes** asked if she believes the pay-back provision in Wyoming has discouraged students from involving themselves with WWAMI. **Ms. Pouliot** answered "no." She said that as far as Wyoming students go, right now they have 16 seats available and at the program's start, there were 10-12. She believes that most students do realize that is part of their commitment, and students who choose not to go that route, choose medical education in other areas. She said traditionally there is enough interest to fill those slots. **Representative Rusche** asked if the student tuition, not the state support, is the same for Wyoming students as for Idaho and others. **Dr. Turner** answered that in Wyoming, the state pays full cost of medical education to participate in the WWAMI program, not only the out-of-state differential but also tuition and fees; at all the other WWAMI states including Idaho, residents pay their own tuition and fees and the state pays the differential on out-of-state.

Dr. Caruthers discussed the third alternative. He said that MGT had serious concerns about accreditation and whether a joint medical school that was initiated by the three universities could get accredited easily, and thought it might have a slightly greater cost due to coordination of three schools.

Dr. Caruthers addressed assessment of expansion of graduate medical education programs.

Representative Rusche expressed concern regarding the assumption that experienced physicians, preceptor, trainer, etc. is low-cost, and stated that it takes time to prepare and do education well, even on a postgraduate level and he asked if **Dr. Caruthers** had considered that as part of his assessment that GME was relatively inexpensive. **Dr. Caruthers** responded that it ought to be relatively inexpensive due to more players in the payment mix, the hospitals supporting some costs. He said that historically, twenty years ago, many physicians were willing to donate time to serve as mentors for medical students, but it is now much more difficult to find physicians willing to commit that amount of time. He said the medical schools have actually planned to buy one-quarter of a person's time at the going rate, so if a physician gets paid $250,000, they would be paid $62,500 to supervise students.

President Vailas said that one consequence of residency programs, one of the positive outcomes, in addition to a higher retention rate of physicians, is that some residents who become physicians, also become faculty and stay in Idaho because they were educated by their mentors. He said that in the ten years ISU has been accredited, it has tripled its medical faculty base. **Senator Geddes** asked if at ISU a number of physicians are assisting in the educational process of medical science classes. **President Vailas** responded that is correct, adding that there is another huge benefit which is: as the physicians become accustomed to an academic setting, as they become faculty, they also gain experience in getting other funding sources, such as clinical trials that provide a significant benefit; they take patients who qualify for pathology, many of whom are uninsured, and these trials cover their medical costs, not the state. At the same time, physicians build their reputations, and he said the more important benefit is that they start building a referral network, due to their relationships with education, and that grows more and more.

Dr. Caruthers went over a summary of opportunities for Idaho, pointing out current programs, new distributive model, expanded contract programs, new joint medical school and expanded GME programs. **Representative Rusche** asked **Dr. Caruthers** to give a guestimate on a time line as to physicians actually entering practice using the three models. **Dr. Caruthers** answered that it takes four years of medical school and a minimum of three years of residency. In addition, he said that based on other start-up schools, the development of a new medical school would require about 4-5 years before provisional accreditation would be granted and the charter class enrolled. He added that the third alternative would take longer, due to more institutional negotiations. He said there is a new WWAMI proposal that could double the number of Idaho student seats in increments of five at a time, already accredited, which would save time on faculty recruitment, etc.

President Vailas asked **Dr. Caruthers** if his last statement was referring to seats and not an

Idaho medical school. **Dr. Caruthers** said that he has seen a PowerPoint presentation recently which was short on specifics, adding that presumably it would have more characteristics of an Idaho medical school, with the corporate office still being in Seattle. He said Idaho might be in a much better position, over time, to possibly spin-off Idaho's own medical school. **President Vailas** asked for clarification about whether he had seen actual proposals of a distributive model that would be cost effective, might take longer, but would have the greatest economic impact. **Senator Geddes** asked why it is to the advantage of the University of Washington to expand the Idaho WWAMI seat numbers. **President Daley-Laursen** answered that the University of Washington is a regional medical school and wants to be just that. **Senator Geddes** asked what the incentive is for the University of Washington, wondering if they are receiving more from an Idaho student in their medical program, in addition to perhaps the out-of-state fees that Idaho pays, than what they would receive if they accepted one more student from their own state. **Dr. Turner** said that a program can expand seats, but if a four-year program is developed in Idaho, the two go hand-in-hand because if you simply expand seats, the bottleneck is in the 2nd year at Seattle. So UW's proposal is to both expand seats and offer a four-year program, then it doesn't put pressure on the Seattle campus. It is to their advantage because it's their reputation, and they want to compete and remain the number one primary care school in the nation. **Senator Geddes** still wondered why they would want to do this in Idaho, rather than Spokane, still providing that regional coverage. **Dr. Turner** said the Spokane program probably will grow into a four-year program eventually, but UW has a commitment to Idaho.

President Vailas said a medical school is not just about training doctors. It also enables a state to steward their future in health care, build infrastructure that would support containing health care costs, build capabilities of their higher educational institutions (including access to medical research funding and clinical trials), and access to many economic development opportunities.

Dr. Caruthers said that he hoped everyone understands that the Universities of Washington and Utah have been very good friends to citizens of Idaho for a long time and that nothing in the MGT report, from his standpoint, is critical of what they have been doing, emphasizing the good relationship. He said he had been surprised at how strong the WWAMI relationship is, and he didn't think that they view themselves as the University of Washington Medical School, but rather they truly view themselves as a regional medical school. He said that Idaho needs to significantly expand both undergraduate and graduate medical educational opportunities. Idaho needs a medical education strategy that provides greater control over the numbers and types of students admitted that takes advantage of past investments.

Senator Geddes said that he had extended an invitation for **Governor Otter** to join this meeting, but he had other commitments, and that he sent his representative. **Mr. Clete Edmunson** was recognized from **Governor Otter's Office**, and he said the **Governor** had apologized for not being able to attend today's meeting, stating that **Ms. Joyce McRoberts** was leading the **Governor's** Select Committee on Health Care, expressing appreciation for raising the level of the medical education discussion through this interim committee. He said that the **Governor** really appreciates the fact that it is made up of members other than legislators, having included all interested parties together, recognizing the need for the future and that Idaho is not producing enough doctors to satisfy the growing need. He said that the **Governor** would like to

see one similar recommendation, including short-term as well as long-term goals, from all three groups. He said that WWAMI, residencies, and a possible future medical school are all going to play a part in medical education in Idaho, encouraging everyone to work together toward common goals.

Ms. Pouliot passed out a handout entitled "Idaho Medical Association House of Delegates," a copy of which is attached (Attachment 3), and began by stating that the Idaho Medical Association (IMA) was very pleased to be involved in this process and their member physicians are very engaged in this discussion from various angles. She said their House of Delegates recently met to set direction and policy for IMA, and shared with the committee their resolution that was passed by the IMA.

President Vailas asked if IMA specified what type of four-year medical education program it supports? **Ms. Pouliot** answered that it did not; their policy does encourage the IMA to evaluate all three models presented in the MGT report, without prejudice, adding that their top priority is to establish an Idaho educational program, not favoring one model or another.

Mr. Matt Freeman, Principal Budget and Policy Analyst, Legislative Services Office, was the next presenter. His presentation can be viewed as an attachment to these minutes (Attachment 4). He talked about national trends in meeting the demand for more physicians, addressing physician shortages, projected first-year enrollment for new or planned medical schools, new or expanded branch campuses, WICHE Region Medical School expansion activities, barriers to expansion, and physician workforce rankings, physician maldistribution, and methods to address maldistribution. **Mr. Freeman** emphasized that maldistribution is one of the most pressing issues, not unique to Idaho, but nationwide, and he addressed what some other states are doing.

Mr. Newcomb asked if there were any figures showing whether or not endeavors are effective in getting physicians to practice in rural areas. **Mr. Freeman** said he had not seen any overall data, pointing out methods that are being used to address maldistribution. **Dr. Caruthers** said he was not familiar with new programs being described by **Mr. Freeman**, adding that when MGT was developing the plan for the medical school at Florida State, they looked at a program in Minnesota to address rural physicians and they do have a much higher placement rate there, designed for physicians going to rural areas to practice for several years, residing with other physicians, and very intensive. There may be a special selection pool trying to target students for that program he said. **Representative Wood** asked if there was a specific selection criteria associated with that particular program. **Dr. Caruthers** responded that he thinks that there are incentives, such as funding.

Mr. Freeman finished talking about what some of the Western Interstate Commission on Higher Education (WICHE) states were doing to address physician maldistribution and trying to provide incentives for students to practice in rural areas. Another interesting example he pointed out was Florida State University (FSU), the first new allopathic medical school created in 2000, the first in twenty years. Since 1970 they had been delivering a first-year medical school to thirty students who transferred on to the University of Florida for their remaining three years. He found the enabling legislation interesting that created this medical school, being very

prescriptive. He said it mandated a rural clinical rotation, training track with five community clinical training sites and authorized a sixth training site based on emerging state needs. He was told that the FSU model could substantially change the demographic of new physicians entering the workforce in Florida. **Dr. Caruthers** said that FSU has really focused on recruiting students on more than test scores and grades. He said that if Idaho had their own medical school, certain things could be targeted in curriculum and selection process to meet state needs.

President Vailas asked if Tallahassee had a residency program established before the medical school was proposed. **Dr. Caruthers** answered that they have had a family residency program for many years.

Mr. Freeman next addressed return rates/retention of graduates and predictors of where physicians may end up practicing. With regard to residency programs, he said that fifty percent of the graduates of the Family Practice Residency of Idaho practice in Idaho in rural or under-served areas. He talked about payback and service requirements, adding that using WICHE as an example, two optometry seats are bought annually by Idaho, there being no service requirement for that. Any graduate level program at a state university clearly has a portion being subsidized by the state with General Fund dollars, with no service requirement or repayment requirement, which he thought might be something to consider, clearly a policy decision to be thought about carefully.

Mr. Freeman next addressed the costs for starting a medical school and expanding medical education, saying that there are so many variables that it makes figures difficult to isolate. He discussed the cost of additional WWAMI seats as well as citing two new bricks and mortar medical schools in Florida.

Mr. Freeman spoke to the start-up and ongoing costs for the WWAMI Spokane track. Then he discussed the cost of purchasing seats through the WICHE Professional Student Exchange Program. **Representative Rusche** asked about the WICHE state support fee which is a lot less than the current U of U or WWAMI contract, asking if the rest was from tuition. **Mr. Freeman** said that it was the same concept where the state support fee is buying down out-of-state tuition costs, so students still pay the equivalent of in-state tuition.

President Vailas asked if the existing inventory of a resource of any institution would have significant impact on the kind of request made to the Legislature or to a student. **Mr. Freeman** said that clearly any type of analysis on costs of ramping up a medical education program should take into account existing assets.

Mr. Freeman talked about the steps necessary for undergraduate medical education accreditation. **President Vailas** asked if there was a slide on graduate medical education accreditation status. **Mr. Freeman** did not have a slide on that. **President Vailas** said that he brought it up because it is very complicated and highly difficult to get accreditation and to be responsible for it, which he said the state of Idaho has successfully done in several places.

Representative Rusche asked**:** when branch campuses are discussed, with regard to expansion,

is the accreditation process different for those medical education facilities. **Dr. Turner** answered that if you are going under an existing accreditation, then the increase triggers a site visit and a self-study, but it doesn't change accreditation status, adding that you are asking for re-accreditation as an expanded body.

Mr. Freeman then talked about expanding medical education, pointing out that **Dr. Caruthers** had a good summary of Idaho's existing residency programs found on page 2-13 of the full MGT report and provided an overview of the typical start-up and operating costs on page 5-9. **Mr. Freeman** discussed a number of factors must be considered when expanding residencies. He said that subject to approval by the SBOE, the residency programs will be requesting additional funding in FY2010 and each new residency position costs approximately $70,000 which reflects a salary of about $46,000 plus benefits. He mentioned that the Idaho Advanced Clinician Track is jointly operated, received their first state funding in 2008 and the state has agreed to pick up ten percent of the cost. The Boise Veterans Administration will fund four residents, and St. Alphonsus and St. Luke's will share the remaining operating expenses equally. This was a way the state was able to start up another residency program at minimal cost due to the hospitals stepping up to cover the bulk of expenses. He said there is also an internal medicine residency through the University of Washington, Seattle/Boise primary care internist program, the second year being spent at the Boise Veterans Administration, ten residents per year, with no state funding, but it is a Boise track provided by the University of Washington.

Senator Geddes asked **Ms. McRoberts** to inform the committee how this committee's information can correlate with the **Governor's** Select Committee on Health Care. **Ms. McRoberts** said this works in very well with the work they are doing, stating that the **Governor** has asked the Select Committee on Health Care to look at the feasibility of a medical school. She said the committee is going to meet with several medical schools this month.

Senator Geddes discussed agenda items for future meetings and received many suggestions from the attendees. The next meeting will be held on September 15, 2008, in Boise. The meeting was adjourned at 4:03p.m.

Attachment 1: PowerPoint by Dr. Kent Caruthers, MGT of America, Summary Medical Education Study Final Report, MGT of America, Inc., August 12, 2008;
Attachment 2: Idaho State Board of Education, Medical Education Study Final Report, Response to Questions Raised at Final Presentation, Submitted December 31, 2007 (Revised January 3, 2008);
Attachment 3: Idaho Medical Association House of Delegates, Resolution 01(08), August 8-10, 2008;
Attachment 4: PowerPoint presentation given by Matt Freeman, Principal Budget and Policy Analyst, Legislative Services Office, to Medical Education Interim Committee, August 12, 2008.